Filed 2/23/05 Gaither v. Enevoldsen CA5

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIFTH APPELLATE DISTRICT

GERI GAITHER,

Plaintiff and Appellant,

v.

LARS ENEVOLDSEN,

Defendant and Respondent.

F042990

(Super. Ct. No. 254963)

OPINION

APPEAL from a judgment of the Superior Court of Stanislaus County. John G. Whiteside, Judge.

Dreyer, Babich, Buccola & Callaham, William C. Callaham and Stanley P. Fleshman for Plaintiff and Appellant.

McCormick, Barstow, Sheppard, Wayte & Carruth, Matthew K. Hawkins and Todd W. Baxter for Defendant and Respondent.

-ooOoo-

This is a suit for damages brought by Geri Gaither against Lars Enevoldsen, M.D., in which Gaither alleges the doctor performed a surgical procedure on her for which he had not obtained her informed consent. Gaither's complaint was reduced eventually to two main causes of action. The first, for negligence, asserted Enevoldsen had obtained her consent to the procedure he performed without having fully explained all the risks. The second, for battery, asserted Enevoldsen had not obtained her consent at all because

the procedure he performed was substantially different from the one he had described to her.

The jury, by special verdict, found that Enevoldsen had not disclosed all relevant information about the procedure, but that a reasonable person in Gaither's position would nonetheless have consented to the procedure had she been given the information. It thus found, as to the negligence cause of action, that Enevoldsen's failure to disclose had not caused Gaither to suffer any harm. However, the special verdict form did not require the jury to make a determination as to the battery cause of action, i.e., whether the procedure Enevoldsen actually performed was substantially different from the one he had discussed with Gaither. Gaither moved for a new trial on this ground. The court denied the motion, and this appeal followed. We will affirm the judgment.

FACTS AND PROCEEDINGS

Gaither, a 28-year-old registered nurse, first began thinking seriously about getting breast implants -- a surgical procedure known as augmentation mammoplasty -- after her friend Rachel got them in the fall of 1998. Gaither thought Rachel looked "wonderful" and so she contacted the plastic surgeon who had performed Rachel's procedure, Dr. Lars Enevoldsen.

Gaither and her fiance, David Loureiro,[1] met with Dr. Enevoldsen at his office on March 4, and again on March 25, 1999. She told him she wanted, in her words, "rounder, perkier-looking breasts" with "[j]ust a little fuller, rounder shape." Or, as the doctor would state it, she was less interested in larger breasts than in "improvement in the shape of the breast with more fullness superiorly [i.e., in the upper part of her breast]."

---

[1] Gaither and Loureiro were married on October 2, 1999, and divorced sometime before this case came to trial in January of 2003.

Dr. Enevoldsen explained to Gaither that he could insert an implant in her breast through an incision made in any one of three places. The first and most common site for the incision is in or near the "inframammary fold," referring to the area at the base of her breast where it joins the skin of her chest. The second option was a "periareolar" incision along the edge of her areola: the darkly-pigmented skin around her nipple. And the third option was an "axillary" incision near her armpit. Gaither, who was especially concerned about scarring, opted for the periareolar approach, and in particular for an incision at the lower or "inferior" edge of her areola. The implant procedure -- a "bilateral subglandular augmentation mammoplasty" -- was scheduled for March 31, 1999.

Dr. Enevoldsen also discussed with Gaither the possibility that the augmentation surgery, although it would probably give her breasts some "lift" as well as size, might not be enough by itself to give her the "superior fullness" she wanted. He suggested a second procedure, known as a "mastopexy," for this purpose. It is this *lift* procedure, rather than the *augmentation* procedure, that would become the subject of the present dispute.

Mastopexy is directed at a condition known as "ptosis," which refers to sagging or drooping breasts. The procedure involves, generally speaking, removing a section of skin from the area around the areola, and then drawing together the remaining skin on either side of the excision to lift and reshape the breast, and raise the nipple-areolar complex on the breast mound. Gaither's breasts were only mildly ptotic.

The most aggressive, and the most effective, type of mastopexy procedure is the "anchor," named after the shape of the scar it leaves: around the areola, vertically down from the areola to the inframammary fold, and then laterally in both directions along the fold. A variation of the procedure omits the incision along the fold, but still leaves a scar around the areola and down from there to the bottom of the breast. It is sometimes called a "vertical scar" mastopexy. Dr. Enevoldsen described this vertical scar procedure to Gaither, and she emphatically rejected it because of the extensive scarring.

The other types of mastopexy omit the vertical scar, and range along a continuum from a "concentric" mastopexy to a "superior crescent" mastopexy. A concentric or "donut" mastopexy involves two concentric, circular incisions around the areola: one outside the areola and the other inside or at the edge of the areola. The donut-shaped piece of skin between the two incisions is removed, and the skin on either side is sutured together. A variation of this procedure is sometimes known as an "eccentric" mastopexy, meaning the inner incision may be offset within the outer one. That is, the inner and outer circles may be tangential at the bottom of the areola, and offset at the top. In either case, the incisions go all the way around the areola, and so are said to be "circumareolar."

A superior crescent mastopexy involves two incisions at the top of the areola, each going from about the ten o'clock to the two o'clock position. The inner incision follows the edge of the areola, and the outer one follows an arc higher on the breast, such that the section of skin in between, which is removed, has a crescent shape. The remaining skin on either side of the crescent is then sutured together.

All Dr. Enevoldsen's notes, from his two office interviews with Gaither and from a preoperative visit on March 31st, reflect an agreement to perform, in a single operation, an implant procedure and possibly a superior crescent mastopexy if, after the implant was inserted, the doctor determined Gaither's nipple-areolar complex was not high enough on the mound of her breast. As Gaither recalled the agreement:

> "… [A]t some point in the conversation the position of my areolae came up, and I was … told that putting an implant in alone might not position my areolae appropriately on my chest, which is why it all came into play, I think, about the lift, crescent lift. And we discussed that with him and that wouldn't be done unless absolutely he went in and placed an implant and it didn't look right, and then he would do a small incision at the top and take a little sliver of skin out and lift my areola[] up so it wouldn't look out of position or out of place."

In fact, however, the procedure Enevoldsen actually performed was an "eccentric-concentric" mastopexy, or as he characterized it in his postoperative report, a "[b]ilateral augmentation mastopexy using eccentric circumaroelar technique."

The doctor testified that, notwithstanding his failure to document it anywhere in his notes, he had discussed the "eccentric-concentric" mastopexy procedure with Gaither, and had explained its risks to her, including the risk of the result that eventually occurred. Gaither, on the other hand, testified Enevoldsen had *not* explained the procedure to her, and she had not given him her consent to perform it. David Loureiro, Gaither's fiance, likewise testified Enevoldsen never mentioned the possibility of performing a concentric mastoplexy.

Dr. Enevoldsen also said he had arranged for Loureiro to come into the operating room to give an opinion, once the implants were in place, about whether and what type of mastopexy to perform. According to the doctor, he had created "pockets" in Gaither's breasts; installed temporary implants ("sizers") having different capacities; and stapled ("Taylor-tacked") the incision closed to hold the sizers in place. He then sat Gaither up (she being unconscious), "cleaned everything up," and only at that point invited Loureiro into the room. Gaither's breasts had previously been marked with a pen to show where incisions would need to be made for either a superior crescent or a concentric mastopexy. Enevoldsen continued:

> "I remember him [Loureiro] coming in here and me showing her and him saying that one is clearly too big. I can't remember if one was too small. He wanted something in between[.] ['L]et's look at the appearance of the breast, see the way the nipple is low?' [¶] Ummm, he goes, 'Yeah, that doesn't look good.'
>
> "'Let me show you what' -- I pull the superior crescent up here and stapled -- that really doesn't look like that. Pulls up the nipple, the bottom of the breast hangs down.

> "'Let me show you when I do the concentric mastopexy,' which pulled everything up and I adjusted it nicely, and he said 'Yeah, that looks a lot better.' I agree and that's the way we left it."

Loureiro, on the other hand, testified he went into the operating room only briefly, and only to express an opinion about Gaither's breasts with the different size implants.[2] Dr. Enevoldsen acknowledged the disagreement, but responded:

> "I think I pretty much made up my mind she was going to need the mastopexy before he come into the room. Again, he was there primarily deciding on size, but also to give some input. Again, like I said, if he had said, 'You know what, they look just fine that way, she is going to be happy with that low nipple,' then I would not have proceeded with the mastopexy."

Concentric mastopexy is a somewhat controversial lift procedure that is used only infrequently due to the risk of complications, and the risk increases when the procedure is performed at the same time as an augmentation. The risks are, most notably, an enlarged areola, wide scars, and flattening of the breast. Dr. Enevoldsen had performed only a few concentric mastopexies before Gaither's procedure; somewhere between three and five by his estimate. And he acknowledged he did not perform Gaither's procedure according to guidelines proposed by a recognized expert in the field; he had not, in particular, made the inner incision within the areola so as to remove more pigmented then nonpigmented skin, a technique intended to reduce the risk of an enlarged areola.

Gaither's areolae did, in fact, become significantly enlarged after the surgery, from about five centimeters in diameter to about eight centimeters.[3] Her right breast was

---

[2] According to one of the experts who testified at trial, the procedure Enevoldsen described -- tacking the breasts to show the effect of different mastopexy procedures, and swapping different size implants -- would have taken 10 to 15 minutes "in adept hands, with a good assistant holding things while you staple and whatnot."

[3] There are 2.54 centimeters in an inch. Therefore, Gaither's areolae had increased in size from a little less than two inches to a little over three and a half inches in diameter.

noticeably higher than her left, and the shape of her breasts was not full and round as she had wanted, but "kind of oblong, cone-shaped." She complained to Dr. Enevoldsen, who urged her to be patient and to do exercises to adjust the position of the implants. She did as he said, but became increasingly frustrated at the seeming lack of any improvement. Finally, at a meeting on July 15, 1999, Gaither became very upset and demanded that the doctor do something to fix these problems. His response, she testified, was rude and disinterested, and he said he would do another surgery only if she paid the full price for it. Dr. Enevoldsen acknowledged his "poor communication skills," and said he had misperceived the depth of Gaither's distress, but testified he believed at the time it was "way too early" to do anything. He also said it was his policy on follow-up surgeries to charge less than full price; to continue to charge for the operating room, anesthesia, and supplies, but to forego payment for his services.

On August 6, 1999, Gaither consulted a second plastic surgeon, Dr. James Hoyt, about the same three problems: enlarged areolae, one breast higher than the other, and a lack of superior fullness. She was most concerned about her enlarged areolae. Dr. Hoyt discussed with Gaither the possible procedures to address each of her concerns. Gaither elected to proceed and, on August 27, 1999, began what would become a series of five corrective surgeries, ending in May of 2002.

On May 22, 2000, Gaither and Loureiro, appearing in propria persona, filed the present complaint against Dr. Enevoldsen. The complaint asserted four causes of action. The first, for "professional negligent failure to obtain informed consent," alleged both that Enevoldsen failed to obtain Gaither's informed consent, and failed to competently perform the augmentation surgery. The second, for invasion of privacy, alleged that he disclosed confidential information about her surgery to a third party. The third alleged negligent infliction of emotional distress, and the fourth alleged loss of consortium.

A nine-day trial began two and a half years later, on January 13, 2003. Loureira failed to appear for trial (he and Gaither had by then divorced) and was dismissed from

the case, as was the fourth cause of action. It appears the third cause of action was also dismissed. At the conclusion of Gaither's evidence, the court granted Enevoldsen's motion for nonsuit as to the allegation he performed the surgery negligently. At the conclusion of all the evidence, the court instructed the jury, at Gaither's request, on the additional theory of lack-of-consent battery, as well as lack-of-consent negligence. The case went to the jury on these two theories, along with the invasion of privacy cause of action.

The jury found by special verdict that Dr. Enevoldsen had failed to disclose "all relevant information [to] enable [Gaither] to make an informed decision regarding the operation [he] performed …." But, it also found that "a reasonably prudent person in [Gaither's] position [would] have consented to the operation if the person had been adequately informed of all the significant risks …." And it found that Dr. Enevoldsen had not disclosed medical information about Gaither without her authorization. On this basis, judgment was entered in favor of Enevoldsen on February 13, 2003.

Gaither filed a motion for a new trial on March 18, 2003, on two grounds: the special verdict failed to address her battery theory of liability, and the evidence failed to support the jury's "reasonably prudent person" finding. The court denied the motion following a hearing on April 29, 2003. It explained:

> "Okay, My feeling of the evidence in this case is that the -- I think the jury found is that they believed that [Gaither] would have consented to a procedure regardless of what procedure she was informed of other than a vertical scar mastopexy. And that she was, as somebody [i.e., Gaither's friend Rachel] put it, gung ho to do this procedure, and was going to go ahead with it regardless. I think that's what they -- that's what they found, basically. And that was sort of my sense of the evidence as well.
>
> "And also I don't feel that the procedure which was performed was substantially different than the procedure which was explained such as to have constituted a battery under the law.

"So I don't believe that the jury would have reached any different conclusion had the question been submitted to them. And the motion for new trial is denied."

An order denying the motion was filed on June 13, 2003.

On May 5, 2003, Gaither filed a notice of appeal from the judgment.

DISCUSSION

Gaither maintains the trial court erred by omitting from the special verdict form a question that would have required the jury to make a necessary finding with regard to her cause of action for battery.

She relies for this argument on the distinction drawn in *Cobbs v. Grant* (1972) 8 Cal.3d 229 (*Cobbs*) between negligence and battery in the context of informed consent to a medical procedure. In *Cobbs*, a patient who suffered complications from surgery sued the surgeon on two theories: the surgeon had performed the operation negligently, and/or his failure to disclose the risks of the operation vitiated the patient's consent. The jury returned a general verdict in favor of the patient. On review, the Supreme Court found there was insufficient evidence to support the negligent performance theory and, because it was not possible to determine if that was the theory upon which the jury relied for its verdict, the court reversed the judgment. However, the court then went on to address the informed consent/medical battery theory for the benefit of the lower court on retrial. It concluded:

"Where a doctor obtains consent of the patient to perform one type of treatment and subsequently performs a substantially different treatment for which consent was not obtained, there is a clear case of battery. [Citations.] [¶] However, when an undisclosed potential complication results, the occurrence of which was not an integral part of the treatment procedure but merely a known risk, the courts are divided on the issue of whether this should be deemed to be a battery or negligence. [Citations.] California authorities have favored a negligence theory. [Citations.] [¶] …

"We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to

> perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence." (*Cobbs*, *supra*, 8 Cal.3d at pp. 239-241; see also *Conte v. Girard Orthopaedic Surgeons Medical Group, Inc.* (2003) 107 Cal.App.4th 1260, 1267-1268; *Ashcraft v. King* (1991) 228 Cal.App.3d 604, 609-610 [conditional consent].)

This definition of medical battery is reflected in the jury instructions given in this case, as follows:

> "A physician has a duty to obtain the consent of a patient before treating or operating on the patient. Consent may be express or implied from the circumstances." (BAJI No. 6.10.)

> "The performance of an operation or rendition of treatment to which the patient has not consented is a battery. [¶] Where a physician or surgeon contains [*sic*, obtains] consent of the patient to one type of treatment or operation and subsequently renders substantially different treatment or performs a substantially different operation, it is likewise a battery. [¶] A battery renders the physician subject to liability for any injury resulting therefrom." (BAJI No. 6.10.5.)

Gaither asked the court, in an unrecorded portion of the proceedings, to include a question in the special verdict form requiring the jury to decide whether the procedure Dr. Enevoldsen performed (i.e., an "eccentric-concentric" mastopexy) was substantially different from the procedure for which he had obtained Gaither's consent. The request assumed, of course, that Gaither had consented only to a superior crescent mastopexy. The court modified the special verdict form, but declined to add a "substantial difference" question. The substance of the discussion was later placed on the record as follows:

> "MR. CALLAHAM [Gaither's attorney]: … My concern is we actually have two types of lack of informed consent. Two theories on lack of informed consent on the case. One is simply getting consent for a procedure, but without fully advising the patient of all the material information, and that is one type of inform[ed] consent. But the other is

battery, which means getting perhaps the very adequate informed consent for one kind of procedure, but then doing a substantially different procedure on a patient. I requested that we deal with that specifically with a separate question on the verdict form, and that I had written one out. [¶] My proposed question would simply have been:

> "'Did the defendant obtain from the plaintiff consent to perform one type of operation and then subsequently perform a substantially different operation?'

"That is in keeping with the instructions -- BAJI instruction that is describing the lack of informed consent as battery. I felt it should be part of the verdict form.

"THE COURT: Okay. Thanks. [¶] Just for the record, my thought on what we did would cure that. The [first question on the] original special verdict form said:

> "'Did the defendant disclose to the plaintiff all relevant information which would enable plaintiff to make an informed decision regarding the proposed operation to be performed by the defendant?'

"And I thought [if] we excised the word 'proposed' and the words 'to be,' that would cover consent to any operation actually performed on the plaintiff, regardless whether the consent was to perform another operation or not. [¶] In any event, that is what we did on that."[4]

Gaither contends this modification of the first question on the special verdict form did not succeed in putting the issue of battery before the jury because the second question -- the "reasonably prudent person" test -- was meant only to determine proximate cause in informed-consent *negligence* cases. That is, Gaither's battery claim rests on the premise that Dr. Enevoldsen obtained her informed consent to perform one procedure (a superior

---

[4] We reject Enevoldsen's contention this exchange establishes that Gaither invited error, or approved or acquiesced in the changes made by the court in the special verdict form, such that she should be precluded from challenging the adequacy of the verdict form on appeal.

crescent mastopexy) and then actually performed a substantially different procedure (an "eccentric-concentric" mastopexy). This, Gaither argues, was a battery without regard to what a reasonably prudent person would have done under the circumstances.

We agree in principle. It is not a defense to battery that a reasonable person, other than the victim, might have consented to it. (See *Thor v. Superior Court* (1993) 5 Cal.4th 725, 735-736 [competent informed adult has the right to refuse treatment even if refusal is medically irrational]; 5 Witkin, Summary of Cal. Law (9th ed. 1988) Torts, § 352, p. 439.) It follows then that the question should have been put to the jury, consistent with the battery instruction, whether the procedure Enevoldsen performed was substantially different from the one for which he had obtained Gaither's consent. However, we do not believe there is any reasonable possibility under the present circumstances that the jury would have found the two procedures were substantially different. Indeed, we conclude as a matter of law they were not.

We begin by noting that the phrase "eccentric-concentric," when used to describe the type of mastopexy Dr. Enevoldsen performed, is a contradiction of terms. The word "concentric" refers to two circles, one inside the other, having the same center point; the word "eccentric" refers to two such circles *not* having the same center point. (Webster's New World Dict. (2d college ed. 1982) pp. 293, 440.) The two circular incisions made by Dr. Enevoldsen could not have been both concentric and eccentric. In fact, they were eccentric: the inner incision was circumareolar, following the edge of the areola all the way around; the outer incision was tangential to the areola at the bottom, a bit wider at the sides, and higher than the areola at the top by about one and a half centimeters.

Thus, a more accurate term for the procedure is the one Enevoldsen used in his postoperative report, where he referred to it as a "[b]ilateral augmentation mastopexy using eccentric circumareolar technique." The principal difference between a superior crescent mastopexy and the type of mastopexy Dr. Enevoldsen performed is that the latter

procedure involves an incision around the entire areola, whereas the former involves an incision along only the upper half of the areola.

The difference is important in this case because Enevoldsen, at Gaither's request, used an inferior periareolar incision, i.e., an incision along the lower half of the areola from the nine o'clock to three o'clock positions, to insert the implants. Thus, even if he had done a superior crescent mastopexy, that procedure in combination with the implant procedure would have resulted in an incision going all the way around, or nearly all the way around, Gaither's areolae.

Dr. Enevoldsen was asked by his attorney at one point in his testimony to assume Gaither was correct in claiming a superior crescent mastopexy was the only procedure he had discussed with her (other than a vertical scar mastopexy). On this premise, he was then asked to explain how it was that the superior crescent mastopexy turned into an "eccentric circumareolar" mastopexy.

> "Q. Why is it in your judgment that you extended the amount of the skin removed down the side [of Gaither's areolae] when you actually did the operation?
>
> "A. She already had an incision along here [referring to a diagram]. We discussed we were going to make an incision along the bottom [of her areola] for the purpose of putting in a breast implant.
>
> "Q. …You heard her [Gaither] say she thought that was going to be a very small incision. What's the normal size cut or incision that you make for introduction of an implant if you are going in the periareolar approach?
>
> "A. I will usually make them from 9:00 to three o'clock.…
>
> "Q. Did you explain she was going to have an incision the entire circumference of the areola?
>
> "A. Yeah. In essence, I did. We are definitely going to have this incision like so. It was our hope that we could get away with just putting in breast implants and getting her the shape, the fullness, perkiness and the roundness that she wanted, but it was also discussed that that may not work.…

"Q. … [W]hy did you intraoperatively take an additional amount of skin on each side of that areola?

"A. Okay. I used that Taylor-tacking technique, where before I made any incisions at all, I … basically drew this.… I had drawn reference lines pre-operatively, put the implant in. At that point I realized I probably didn't need to remove quite as much as marked there. I marked where the superior crescent would need to be to get the look we wanted, took the staples and stapled this up there, and that has the effect of pulling the nipple up and kind of improving the contour up here, but it really didn't do much for the shape of the breast down here. It didn't transmit all the way through. So by -- since we already had -- at this point we were going to have an incision going all the way around, the logical thing to do is to continue around and bring it all the way around, take a little more to gather that breast skin up and give her a better contour."

According to the medical literature to which Gaither referred at trial, the risk of enlarged areolae from a concentric mastopexy is less a function of the fact the procedure involves circumareolar incisions than a function of where the incisions are made. The "first rule" stated in the articles is that the inner incision should be made *inside* the areola, such that there is as much or more pigmented areolar skin than nonpigmented breast skin in the donut-shaped section of skin removed from between the two incisions. The risk also depends on the tension at the incision site as determined by the size of the "donut," and by the size of the implants if an augmentation is performed at the same time. The two criticisms leveled against Dr. Enevoldsen were that he excised *no* pigmented skin -- his inner incision was at the edge rather than inside the areola -- and that he performed a mastopexy at the same time as an augmentation rather than waiting to determine whether the augmentation alone would produce a satisfactory result. These two issues go to the question of whether he performed the procedure competently, not whether he obtained Gaither's informed consent to the procedure.[5]

---

[5] While Gaither's expert witness was critical of these two aspects of the procedure performed by Dr. Enevoldsen, and testified he would have done things differently, he did

Elsewhere in his testimony, Dr. Enevoldsen explained that superior crescent and "eccentric-concentric" mastopexies, in terms of the nature of these procedures, lie along a continuum.

> "Q. [by Gaither's attorney] Your description of the [superior] crescent mastopexy, it typically involves making an incision at the superior portion of the areola, from about ten o'clock to two o'clock.…
>
> "A. [by Dr. Enevoldsen] That incision can be made anywhere from ten o'clock to two o'clock, from nine o'clock to three o'clock, from eight o'clock to four o'clock.… [A] superior-crescent-mastopexy procedure doesn't have two specific points where you start and end. It is a procedure where you remove a crescent-shaped portion of skin from the top of the areola, anywhere there is a continuum [*sic*]. At some point that superior crescent comes all the way around and meets at the bottom, then I guess you would have what we call the eccentric-concentric mastopexy …."

Gaither's own expert witness, Dr. Timothy Weibel, testified similarly:

> "Q. [by Dr. Enevoldsen's attorney] Doctor, you said -- when you were asked … about your familiarity with the procedure of the superior crescent and concentric mastopex[ies], you said those were a continuum. [¶] What did you mean by that?
>
> "A. The art and science of plastic surgery for procedures like this and others, it is not etched in stone. You have to go a certain number of millimaters one way or another. You have to -- part of the art is being dynamic and being able to be flexible with a problem at hand and how you are going to solve the problem. Therefore, certain rules or formulas don't apply to every patient. You have to be able to be adaptive and to modify your procedure somewhat with each patient.
>
> "That's what I mean by the crescent, you know, just like the crescent, eventually could become a donut if you wrapped dough around enough [*sic*]. In similar fashion, you have to be flexible here as to how you are going to solve a particular problem. So it is a continuum, start with a

---

not express the opinion that the way Enevoldsen did them fell below the standard of care. It was for this reason that the trial court granted the doctor's motion for nonsuit as to the cause of action for negligent performance.

> small crescent, go to a bigger crescent, may eventually envelop an entire areola, may then become two concentric circles in a very dynamic way."

Dr. Hoyt, who performed the follow-up procedures on Gaither, and Dr. William Pollock, Dr. Enevoldsen's expert witness, likewise testified that superior crescent and "eccentric concentric" mastopexies are but variations of the same basic procedure, and exist along a continuum.

Moreover, the cases cited by the Supreme Court in *Cobbs* as representing "clear case[s] of battery" -- where the procedure performed was "substantially different" from the procedure for which consent was obtained -- reflect a much greater difference than exists in the present case. (*Cobbs*, *supra*, 8 Cal.3d at p. 239.) In *Berkey v. Anderson* (1969) 1 Cal.App.3d 790, for example, a patient who consented to what was described as a simple exploratory procedure like one he had undergone before, was in fact strapped to a table and a large needle inserted into his spine. The court held that, absent consent, this would constitute a "technical battery." (*Id.* at p. 803; see also *Bang v. Charles T. Miller Hosp.* (1958) 251 Minn. 427 [88 N.W.2d 186] [patient consented to prostate resection without being told his sperm ducts would be tied]; *Corn v. French* (1955) 71 Nev. 280 [289 P.2d 173] [doctor performed mastectomy on patient who consented to exploratory surgery]; *Zoterell v. Repp* (1915) 187 Mich. 319 [153 N.W. 692] [patient consented to hernia operation but doctor also removed both her ovaries].)

More recently, in *Perry v. Shaw* (2001) 88 Cal.App.4th 658, a woman who had undergone a very substantial weight loss engaged a surgeon to remove excess skin from her arms, back, thighs, and stomach. The surgeon also proposed to perform a breast lift or enlargement, but the woman expressly and repeatedly refused consent. Nonetheless, in addition to the skin removal procedure, the surgeon enlarged her breasts from a size 34B to a 44DD. A jury returned a verdict in favor of the woman for both negligence and battery, and awarded her over $1 million in noneconomic damages. The issue on appeal was whether the award was subject to the $250,000 limitation on such damages under the

Medical Injury Compensation Reform Act (MICRA; Civ. Code, § 3333.2), which applies to actions based on "professional negligence." The court concluded the limitation did not apply because the intentional tort of battery, which it agreed had been committed in that case, is qualitatively different than professional negligence. (*Perry v. Shaw, supra*, 88 Cal.App.4th at pp. 663-664, 668.)

Applying the meaning of "substantially different" that can be derived from these decisions, it might very well have been an actionable battery if Dr. Enevoldsen had done a vertical scar mastopexy notwithstanding Gaither's refusal to consent to the procedure. But there simply is no support for the conclusion, even assuming Gaither consented only to a superior crescent mastopexy, that the procedure Dr. Enevoldsen actually performed was a substantially different one. This was a case of medical negligence, if anything, not a case of battery.

DISPOSITION

The judgment is affirmed. Respondent is awarded his costs on appeal.

_____
Buckley, Acting P.J.

WE CONCUR:

_____
Cornell, J.

_____
Gomes, J.